THE OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA

JOINT LEGISLATIVE SUNSET REVIEW COMMITTEE 2000 SUNSET REVIEW REPORT

Four Year Overview of the Board's Regulatory Program, Background Paper for the 1999 Public Hearing, Board's Response to Issues and Recommendations from 1999/2000 Sunset Review, and Final Recommendations of the Joint Committee and the Department of Consumer Affairs

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TABLE OF CONTENTS

PART 1.

Osteopathic Medical Board of California

BACKGROUND INFORMATION AND FOUR YEAR OVERVIEW OF THE CURRENT REGULATORY PROGRAM

BACKGROUND AND DESCRIPTION OF THE BOARD AND PROFESSION

The Osteopathic Medical Board of California (OMBC) is made up of 7 members, five doctors of osteopathic medicine (D.O.s) and two public members, all of whom are appointed by the Governor. A member may serve up to three full consecutive terms, with each term lasting three years. The board meets four times a year. Currently, there are no vacancies on the board. The osteopathic field is growing. The OMBC is considering adding members.

Initially established as the Board of Osteopathic Examiners by initiative statute in 1922, the OMBC licenses and regulates doctors of osteopathic medicine. D.O.s are physicians and surgeons within the meaning of California law, and hold the same scope of practice as doctors of medicine. In all respects, D.O.s are legally and professionally equivalent to M.D.s. They are regulated by an entity separate from the Medical Board, as a result of a long-past history of discrimination. Mainstream medicine viewed physicians trained in osteopathic medicine as lesser professionals, and in 1919 succeeded in halting the Board of Medical Examiners' long-standing practice of licensing osteopathic trained physicians. Hence, the 1922 initiative to assure the continued existence of this branch of the medical profession.

The primary difference between D.O.s and M.D.s is that osteopaths focus on the interdependence among all body systems, including the musculoskeletal system. There is a greater focus on manipulative therapy as a means for achieving overall body health.

Subsequent initiative statutes have modified the initial law, to the point that the Legislature now has some degree of authority to amend the osteopathic law. Unlike the Chiropractic Act (which was also enacted by initiative but is not amendable), a 1962 initiative allows for some degree of legislative amendment to the Osteopathic Act. The precise parameters on what the Legislature can and cannot do in relation to the Osteopathic Act have not been established by the courts.

The OMBC operates virtually in the same manner as numerous other licensing boards in state government. It establishes requirements for admission to the licensing examination; it issues licenses to those who pass the examination; it has authority to discipline its licensees. However, there are some significant differences between the OMBC and other boards.

The OMBC is not actually within the Department of Consumer Affairs. Nonetheless, because it is such a small operation (four full-time staff only), it contracts with the DCA to a greater extent than

the Medical Board, which is within DCA. For example, the Medical Board has its own investigators; OMBC contracts with DCA's Division of Investigation. The Medical Board operates its own diversion program for physicians with substance abuse problems; OMBC contracts for these services with the same program used by other DCA licensing bodies.

One effect of this small size is that certain economies of scale are not possible. A small number of extraordinary enforcement cases, for example, can create budgetary problems for the OMB. On the other hand, senior staff, such as the executive officer, can review every complaint that is filed.

In California, osteopathic medicine has not attained the market penetration it has experienced in other states. Where D.O.s constitute up to 20% of the total physician population in some states, they constitute a little over 2% in California (2,100 or so total active licenses, in comparison to approximately 100,000 M.D.s).

Licensing Data

The following table provides licensing data for the past four years:

LICENSING DATA FOR Osteopaths	FY 1995/96	FY 1996/97	FY 1997/98	FY 1998/99
Total Licensed	**Total: 2,552**	**Total: 2,658**	**Total: 2,792**	**Total: 2,949**
Active	1,746	1,840	1,955	2,127
Inactive	806	818	837	822
Applications Received	**Total: 168**	**Total: 210**	**Total: 220**	**Total: 203**
Applications Denied	**Total: 0**	**Total: 0**	**Total: 0**	**Total: 0**
Licenses Issued	**Total: 131**	**Total: 170**	**Total: 220**	**Total: 181**
Renewals Issued	**Total 1,210**	**Total: 1,244**	**Total: 1,396**	**Total: 1,384**
Statement of Issues Filed	**Total: 1**	**Total: 2**	**Total: 0**	**Total: 3**
Statement of Issues Withdrawn	**Total: 0**	**Total: 1**	**Total: 0**	**Total: 1**
Licenses Denied	**Total: 0**	**Total: 0**	**Total: 0**	**Total: 1**
Licenses Granted	**Total: 131**	**Total: 170**	**Total: 220**	**Total: 181**

BUDGET AND STAFF

Current Fee Schedule, Revenue and Expenditure History

Fee Schedule	Current Fee	Statutory Limit
Application Fee	$200	$200
Examination Fee		
Written Examination	$350	N/A
Oral/Practical Examination	$200	$200
Renewal Fee		
Active	$600	$400
Inactive	$300	$400
Delinquent Payment	$150	$100

As of July 1, 1999, the osteopathic physician license renewal fee fell from $300 to $200. Five years ago, in response to budgetary concerns, fees were increased in order to assure an adequate revenue stream to fund appropriate enforcement levels. That statute (Business and Professions Code Section 2455) included a sunset date of July 1, 1999, whereupon the previous fee statute would be reinstated. There was no repeal or extension of that sunset date, and as a result the current fee for renewal is a $200 per year.

The OMBC's revenues have decreased every year since FY 95-96. At the same time, expenditures have increased over the same four-year period. A significant portion of the board's revenues comes from the initial license fee. The other major source of revenue is the renewal fee.

REVENUES	ACTUAL				PROJECTED	
	FY 95-96	FY 96-97	FY 97-98	FY 98-99	FY 99-00	FY 00-01
Initial License	$125,000	$149,000	$162,000	$137,000	$140,000	$150,000
Renewals	$721,000	$690,000	$623,000	$696,000	$528,000 *	$556,000
Subtotal Other Applications	$48,000	$22,000	$54,000	$30,000	$30,000 **	$10,000
Interest and Misc.	$37,000	$56,000	$71,000	$111,000	$33,000	$54,000
TOTALS	**$931,000**	**$917,000**	**$910,000**	**$974,000**	**$731,000**	**$777,000**

EXPENDITURES	FY 95-96	FY 96-97	FY 97-98	FY 98-99	FY 99-00	FY 00-01
Personnel Services	$178,000	$183,000	$186,000	$182,000	$209,000	$250,000
Operating Expenses	$488,000	$642,000	$626,000	$707,000	$713,000	$810,000
(-) Reimbursements						
(-) Distributed Costs						
TOTALS	**$666,000**	**$825,000**	**$812,000**	**$889,000**	**$922,000**	**$1,060,000**

***** renewal fees reduced by 1/3 7/1/99 from 300-200 per year.

** DA supervisor fees eliminated 7/1/01 by SB 1981.

Expenditures by Program Component

The OMBC spends the majority of its budget on enforcement. FY 97-98 enforcement spending was $558,000, a drop of $67,000 from FY 96-97. The licensing expenditures claimed $161,000 in FY 97-98. The licensing expenditures have steadily increased over the past three years. While, the diversion program expenditures were nearly $30,000, the administrative expenditures have risen nearly $10,000 from last fiscal year. These figures are a little incomplete given that the Board did not account for examination or administrative expenditures.

EXPENDITURES BY PROGRAM COMPONENT	FY 95-96	FY 96-97	FY 97-98	FY 98-99	Average % Spent by Program
Enforcement	$481,000	$625,000	$626,000	$709,000	
Examination					
Licensing	$155,000	$168,000	$186,000	$182,000	
Administrative					
Diversion (If Applicable)	$21,000	$20,700	$30,000	n/a	
TOTALS	**$657,000**	**$813,700**	**$842,000**	**$891,000**	

Fund Condition

The OMBC's fund condition is presently favorable. However, there are reasons to be concerned with its long-term adequacy. For example, the increase in enforcement workload has been growing more rapidly than the increase in the number of licensees, indicating that the revenue increase from new licensees will be insufficient to support the enforcement program at some point in the future.

In addition, the bad budget years of the early 1990s continue to play a role in the OMBC fund condition. The Board is spending more each year than it is collecting in annual revenues (and it is arguable that even that level of expenditure has been lower than appropriate in light of late fiscal year curtailment of enforcement activity as spending authority has run out.) It is presently able to make up for this shortfall (and maintain a more than adequate reserve) because it has been fully repaid by the General Fund for all of the monies transferred earlier this decade.[1]

As the chart below shows, fund reserves shrink by 3 to 5 months per year over the next 3 years. At this rate, the OMBC could face major funding shortages by the 2003-04 or 2004-05 fiscal years. While it may be presently premature to seek additional funding sources, it would be worthwhile to consider permanently establishing the $300 renewal fee to assure adequate funding for enforcement activities. The OMBC may also wish to conduct a more detailed evaluation of the cost of its application and examination program in comparison to the revenues collected for those functions.

[1] (As a result of litigation, all special fund monies that were transferred to the General Fund have been ordered repaid. Although the court orders incorporated extended payment periods, the OMBC fund has been fully repaid ahead of schedule.)

ANALYSIS OF FUND CONDITION	FY 97-98	FY 98-99	FY 99-00 (Budget Yr)	FY 00-01 (Projected)	FY 01-02 (Projected)	FY 02-03 (Projected)
Total Reserves, July 1	$1,015,000	$1,048,000	$1,500,000	$1,331,000	$1,179,000	$889,000
Total Revenue	$897,000	$1,346,000	$731,000	$770,000	$770,000	$770,000
Total Resources	$1,912,000	$2,394,000	$2,231,000	$2,101,000	$1,949,000	$1,659,000
Total Expenditures	$864,000	$894,000	$900,000	$922,000	$1,060,000	$1,100,000
Reserve, June 30	$1,048,000	$1,500,000	$1,331,000	$1,179,000	$889,000	$559,000
MONTHS IN RESERVE		**21.65**	**19.04**	**16.73**	**11.27**	**7.26**

LICENSURE REQUIREMENTS

Education, Experience and Examination Requirements

The educational and training requirements for licensure as a D.O. in California are:

1) Two years of pre-professional, post-secondary education,
2) Four academic years of actual instruction in a prescribed curriculum provided by an osteopathic medical school,
3) A diploma or certificate of completion of all formal requirements for graduation from an osteopathic medical school, and
4) One year of postgraduate training in an approved postgraduate osteopathic training program.

Postgraduate training allows the applicant to practice osteopathic medicine up to a year. Upon completion of any postgraduate training in California, an applicant must qualify and apply for a D.O. license.

The OMBC currently has 2 options for qualifying an applicant as having passed a written examination. The course chosen by the vast majority of applicants is passing the National Board of Osteopathic Examiners examination (so-called “national boards”). Most applicants have already passed this examination by the time they apply for California licensure. The Board did not provide pass rates for this examination. The other path is the OMBC’s own written examination. The vast majority of students are able to pass this written exam. Only 9 out of 35 students have failed since FY 94-95. It should be noted that the source of the current California-specific written examination will no longer be preparing this examination for the OMBC (as well as for the other states that include this type of option.) It is doubtful that it would be cost-effective for the OMBC to develop its own examination for the small number of applicants who would opt to pursue that examination in lieu of the national boards.

In addition to the written examination, there is an oral/practical examination. This component focuses on the manipulative skills that are characteristic of osteopathic medicine. This exam has an even larger pass percentage. Most recently, the pass rate was 98% for 213 students..

OMBC WRITTEN EXAM					
	1994/95	1995/96	1996/97	1997/98	1998/99
CANDIDATES	15	11	4	5	7
PASS %	53%	91%	100%	80%	71%
NOTE: The applicant must pass the written exam before attempting the oral/practical exam.					

OMBC ORAL/PRACTICAL EXAM					
	1994/95	1995/96	1996/97	1997/98	1998/99
CANDIDATES	166	180	196	213	213
PASS %	99%	98%	99%	98%	98%
NOTE: The applicant must pass the written exam before attempting the oral/practical exam.					

Because the vast majority of applicants submit proof of passage of national boards at the time of application, and because the oral/practical examination is regularly scheduled at quarterly intervals, and also because the number of applicants is relatively small, there have been no issues or concerns about delay in processing applications or results.

AVERAGE TIME TO RECEIVE LICENSE	FY 1995/96	FY 1996/97	FY 1997/98	FY 1998/99
Application to Examination	6 weeks	6 weeks	6 weeks	6 weeks
Examination to Issuance	10 weeks	10 weeks	10 weeks	10 weeks
Total Average Time	**16 weeks**	**16 weeks**	**16 weeks**	**16 weeks**

Continuing Education/Competency Requirements

Continuing education requirements for osteopathic physicians are comparable to the requirements for M.D.s, and there have not been any significant concerns or changes in this program.

ENFORCEMENT ACTIVITY

ENFORCEMENT DATA	FY 1995/96		FY 1996/97		FY 1997/98		FY 1998/99	
Inquiries	Total:	n/a	Total:	n/a	Total:	n/a	Total:	n/a
Complaints Received (Source)	**Total:**	**145**	**Total:**	**149**	**Total:**	**131**	**Total:**	**162**
Consumer		95		93		86		93
Law Enforcement		2		3		2		9
Medi-Cal/Health Services		3		1		2		6
D.O. and M.D. referrals		1		3		2		7
Insurance Company referrals		2		0		1		1
Other		42		49		38		46
Complaints Filed (By Type)	**Total:**	**N/A**	**Total:**	**N/A**	**Total:**	**N/A**	**Total:**	**N/A**
Complaints Closed	**Total:**	**135**	**Total:**	**141**	**Total:**	**143**	**Total:**	**140**
Investigations Commenced	**Total:**	**21**	**Total:**	**17**	**Total:**	**21**	**Total:**	**21**
Over-Prescribing Narcotics or Self-use		4		7		9		8
Improper Use of License		2		1		4		2
Insurance Fraud		3		1		0		2
Negligence Related		3		1		2		1
Unprofessional Conduct		3		1		3		1
Sexual Misconduct		1		4		2		1
Probation Related		0		1		0		1
Based on Criminal Record		2		1		0		0
Based on Action in Another State		1		0		0		0
Other		2		0		1		5
Compliance Actions	**Total:**	**0**	**Total:**	**0**	**Total:**	**0**	**Total:**	**1**
ISOs & TROs Issued								1
Citations and Fines								
Public Letter of Reprimand								
Cease & Desist/Warning								
Referred for Diversion								
Compel Examination								
Referred for Criminal Action	**Total:**	**0**	**Total:**	**0**	**Total:**	**0**	**Total:**	**2**
Referred to AG's Office	**Total:**	**9**	**Total:**	**14**	**Total:**	**17**	**Total:**	**15**
Accusations Filed		9		5		9		12
Accusations Withdrawn		0		0		0		0
Accusations Dismissed		0		0		0		0
Stipulated Settlements	**Total:**	**2**	**Total:**	**10**	**Total:**	**9**	**Total:**	**6**
Disciplinary Actions	**Total:**	**10**	**Total:**	**9**	**Total:**	**7**	**Total:**	**6**
Revocation		4		3		3		0
Voluntary Surrender		0		1		0		2
Suspension Only		0		0		0		0
Probation with Suspension		2		1		0		0
Probation		4		4		4		3
Probationary License Issued		0		0		0		0
Public Reprimand with Terms and Conditions								1
Probation Violations	**Total:**	**0**	**Total:**	**0**	**Total:**	**1**	**Total:**	**1**
Suspension or Probation						1		1
Revocation or Surrender						0		0
***NOTES:**								

Enforcement Program Overview

As mentioned above, enforcement activity is increasing more rapidly than the growth of the licensee base. The OMBC has not conducted a rigorous analysis of the reasons for this trend. However, it has suggested some reasons. Primarily, the OMBC believes that patients are becoming more informed, and that they are aware of what to expect from a physician, and what to do about it when a problem arises. Additionally, with the heightened awareness that managed care has created, patients are more willing to pursue grievances than in the past. Finally, the pressure of managed care on osteopathic physicians, such as shorter patient visits, financial pressures, and the like, probably is resulting in more patient complaints.

Because the OMBC is such a small program, many functions typically performed by enforcement staff have been performed by the executive officer. However, as the size of this program continues to grow, the "hands-on" at the top approach will be less and less viable. It will also become necessary for the Board to move away from the primarily hard-copy record keeping and monitoring procedure that has worked well in the past.

The OMBC has been seeking budgetary approval to add an additional staff position to improve its ability to manage its enforcement caseload. However, the Board's request recently was rejected by the Department of Finance.

One problem characteristic of the licensing bodies that contract for investigative and prosecutorial services is that late in the fiscal year, spending authority may have been consumed by individual significant cases or by a higher than expected volume of cases. As a consequence, enforcement activity falls off late in the year. This problem has plagued the OMBC numerous times in years past. However, the OMBC asserts that it has not had to curtail enforcement activities in the past two fiscal years for this reason.

The Board reports that it is pleased with its working relationship with the DCA's Division of Investigation. However, it reports some concern about its relationship with the Attorney General's Office. Once an investigation of a complaint has been completed, and the decision is made to pursue disciplinary action against the physician, the Attorney General (AG) represents the Board. The AG prepares the accusation initiating the action against a licensee, and prosecutes the matter before administrative and potentially judicial forums. The Board reports that it receives excellent responsiveness from the AG's San Francisco, Sacramento, and San Diego offices, but that typical delays of up to 24 months from submission to filing an accusation occur in the AG's LA office. The Board did not proffer any explanation for why this dichotomy exists. (It should be noted that the Attorney General has made it a priority to improve its relationship with its administrative enforcement clients, and is currently implementing a state-of-the art time management and billing system that will enable both the AG and its clients to analyze these types of issues.)

The Board also reports that its cases are handled by deputy Attorneys General in the general licensing enforcement unit, rather than the Health Quality Enforcement unit that staffs Medical Board cases.

NUMBER AND PERCENTAGE OF COMPLAINTS DISMISSED, REFERRED FOR INVESTIGATION, TO ACCUSATION AND FOR DISCIPLINARY ACTION				
	FY 1995/96	**FY 1996/97**	**FY 1997/98**	**FY 1998/99**
COMPLAINTS RECEIVED	**145**	**149**	**131**	**162**
Complaints Closed	135	141	143	140
Referred for Investigation	21	17	21	22
Accusation Filed	9	5	9	12
Disciplinary Action	10	9	8	6

Case Aging Data

AVERAGE DAYS TO PROCESS COMPLAINTS, INVESTIGATE AND PROSECUTE CASES				
	FY 1995/96	**FY 1996/97**	**FY 1997/98**	**FY 1998/99**
Complaint Processing	**N/A**	**N/A**	**N/A**	**N/A**
Investigations	**N/A**	**N/A**	**N/A**	**N/A**
Pre-Accusation*	**233**	**207**	**140**	**N/A**
Post-Accusation**	**114**	**110**	**59**	**N/A**
TOTAL AVERAGE DAYS* **	**153**	**159**	**92**	**N/A**

*****From completed investigation to formal charges being filed.
******From formal charges filed to conclusion of disciplinary case.
*******From date complaint received to date of final disposition of disciplinary case.

The table below appears to indicate that the number of investigations completed over the past three years remained stable. Most recently, the majority of these cases were closed within 90 days. The last three years have proven to be very effective in closing cases before 180 days. The AG closed 143 cases in FY 96-97, while in FY 97-98 the AG closed 70. This is a significant drop-off. The AG left 61 cases still open at the end of FY 97-98. In each of the two previous years the AG left a total of 11 cases open. However, because of the relatively small number of cases, and the normal variation in complexity, these numbers may not be statistically significant.

INVESTIGATIONS CLOSED WITHIN:	FY 1995/96	FY 1996/97	FY 1997/98	FY 1998/99
90 Days	8	3	5	N/A
180 Days	4	8	2	N/A
1 Year	7	3	2	N/A
2 Years	0	2	0	N/A
3 Years	0	1	0	N/A
Over 3 Years	0	0	0	N/A
Total Cases Closed	**21**	**17**	**21**	**N/A**
AG CASES CLOSED WITHIN:	**FY 1995/96**	**FY 1996/97**	**FY 1997/98**	**FY 1998/99**
1 Year	132	132	70	N/A
2 Years	6	11	0	N/A
3 Years	2	0	0	N/A
4 Years	0	0	0	N/A
Over 4 Years	0	0	0	N/A
Still open	5	6	61	N/A
Total Cases Closed	**140**	**143**	**70**	**N/A**
Disciplinary Cases Pending		**6**	**61**	

Cite and Fine Program

The OMBC does not have cite and fine authority. The statutes that authorizes licensing boards and programs to adopt regulations establishing a cite and fine enforcement program apply to "any board bureau, or commission within the department . . . ." Because the OMBC is not "within" the DCA, this authority does not apply to it. It is highly probable that the lack of statutory authority was an oversight.

Diversion Program (if applicable)

The OMBC offers participation in a diversion program for its licensees with substance abuse problems. The Diversion Evaluation Committee consultant interviews each applicant for the program. The consultant may recommend medical and psychiatric examination as part of the process of determining the applicant's eligibility. When the applicant is accepted into the program, the Diversion Evaluation Committee has the responsibility to determine when to terminate the applicant's participation.
All the costs of treatment are paid for by the participant (about $300 per month). The OMBC may pay for the administrative costs for the program. The OMBC has, on average, recovered half of its administrative costs for the diversion program.

There have been 27 participants in the history of the program. Five participants have "graduated" from the program. This means that they have completed a minimum of five years in the program and have proven that they are free from abuse problems. Seven of the voluntary participants dropped out before completing the program.

As the table below shows, the OMBC contracts with Occupational Health Services, Inc. for diversion program services. OHS serves a significant number of licensing program substance abuse diversion needs. It is unlikely that a program as small as the OMBC could operate its own program in the same way that the Medical Board does.

DIVERSION PROGRAM STATISTICS	FY 1994/95	FY 1995/96	FY 1996/97	FY 1997/98	FY 1998/99
Occupational Health Services, Inc.	$19,203	$21,000	$20,700	$29,840	$30,240
Amount billed	$16,021	$15,597	$17,855	$29,168	$25,620
Billed/participant	$154	$159	$173	$178	$185
Amount recovered	$7,590	$10,285	$9,520	$17,930	$20,170

Results of Complainant Survey

CONSUMER SATISFACTION SURVEY RESULTS*					
QUESTIONS	**RESPONSES**				
# Surveys Mailed: 129 **# Surveys Returned: 54**	***SATISFIED***			***DISSATISFIED***	
	5	***4***	***3***	***2***	***1***
1. Were you satisfied with knowing where to file a complaint and whom to contact?		35 (66%)		18 (34%)	
2. When you initially contacted the Board, were you satisfied with the way you were treated and how your complaint was handled?		23 (43%)		30 (57%)	
3. Were you satisfied with the information and advice you received on the handling of your complaint and any further action the Board would take?		11 (26%)		31 (74%)	
4. Were you satisfied with the way the Board kept you informed about the status of your complaint?		11 (21%)		42 (79%)	
5. Were you satisfied with the time it took to process your complaint and to investigate, settle, or prosecute your case?		10 (19%)		42 (81%)	
6. Were you satisfied with the final outcome of your case?		7 (13%)		46 (87%)	
7. Were you satisfied with the overall service provided by the Board?		13 (25%)		40 (75%)	

*****The JLSRC directed all board's and committee's under review this year, to conduct a consumer satisfaction survey to determine the public's views on certain case handling parameters. (The Department of Consumer Affairs currently performs a similar review for all of its bureaus.) The JLSRC supplied both a sample format and a list of seven questions, and indicated that a random sampling should be made of closed complaints for a four year period. Consumers who filed complaints were asked to review the questions and respond to a 5-point grading scale (i.e., 5=satisfied to 1=dissatisfied).

ENFORCEMENT EXPENDITURES AND COST RECOVERY

Average Costs for Disciplinary Cases

As discussed in the Overview section, above, the OMBC, because of its small size, is very susceptible to enforcement program budget problems. The data below show a fairly significant variation in average costs of investigation, as well as prosecution. These variations can be explained by the fact that one or a small number of complex cases can have a disproportionate impact on average costs. This unpredictability makes it difficult to accurately project resource allocation.

Because the OMBC is not very automated in its data systems, it reports that it is unable to break down costs by type of case, or apportion staff expense to enforcement or other functions.

AVERAGE COST PER CASE INVESTIGATED	FY 1995/96	FY 1996/97	FY 1997/98	FY 1998/99
Cost of Investigation	$135,000	$230,000	$120,000	N/A
Number of Cases Closed	22	25	18	N/A
Average Cost Per Case	$6,136	$9,200	$6,667	N/A

Cost Recovery Efforts

The OMBC's data systems do not collect information in any systematic way to allow evaluation of cost recovery efforts. The information is hard-copy at best, and often involves oral settlement negotiations as the only source of "demand" information. The Board reports that it has cost recovery orders for $187,000 since 1994, about one-third of which has been collected, and about one-sixth of which will be collected via installment payment agreements. The remainder is viewed as uncollectible.

COST RECOVERY DATA	FY 1995/96	FY 1996/97	FY 1997/98	FY 1998/99
Enforcement Expenditures	481,000	625,000	558,000	N/A
Potential Cases for Recovery*	N/A	N/A	N/A	N/A
Cases Recovery Ordered	N/A	N/A	N/A	N/A
Amount Collected				

*The "Potential Cases for Recovery" are those cases in which disciplinary action has been taken based on a violation, or violations, of the License Practice Act.
Notes: Enforcement Expenditures is the same here as in the Enforcement Activity section

RESTITUTION PROVIDED TO CONSUMERS

The OMBC did not provide any data indicating that it has issued restitution orders. It is unclear the extent to which it may have sought any orders.

COMPLAINT DISCLOSURE POLICY

If the enforcement and disciplinary process results in an accusation (or statement of issues in the licensing process), the outcome is made public. In addition, the final outcome of a disciplinary action is also made public. The Board publishes information on disciplinary action in its newsletter. In addition, in accordance to the Board's adopted policies and procedures for release of information to the public, the staff is authorized to disclose:

1) the date and amount of any malpractice judgments, the court in which the case was filed, and the case number. In addition, Board staff will provide a brief summary of the acts that gave rise to the judgment as that information was reported to the Board.
2) information which the Board has on malpractice settlements of $30,000 or more.
3) any discipline imposed by government agencies, the date of the discipline, the state and governmental entity imposing the discipline, and copies of the disciplinary order.
4) the nature, date, sentence and court of jurisdiction of any felony convictions which have been reported to the Board.

However, as with other boards and licensing programs, much of the complaint and investigative information is not available or confirmable to the public unless the case reaches the stage of filing a formal enforcement action.

CONSUMER OUTREACH AND EDUCATION

The Board provides interested or concerned consumers with a guide to handling consumer problems relating to medical practitioners. The Board recently developed a more specific guide designed to inform an actual complainant of the process the Board follows in attempting to respond to a consumer complaint. This guide is now being sent automatically to anyone who files a complaint. However, the OMBC does not appear to have the resources to mount effective general education/outreach initiatives.

PART 2.

Osteopathic Medical Board of California

BACKGROUND PAPER FOR 1999 PUBLIC HEARING

Identified Issues, Background Concerning Issues, Staff Recommendations and Questions for the Board

CURRENT SUNSET REVIEW ISSUES: This is an initial review of the Osteopathic Medical Board pursuant to Section 101.1 and Section 473.15 of the Business and Professions Code. The following are issues or problem areas identified by JLSRC staff, along with background information concerning the particular issue. Where necessary, the staff of the JLSRC have made preliminary recommendations for members and Department of Consumer Affairs to consider. There are also questions that staff have prepared concerning the particular issue. The Board was provided with these questions and should address each one.

ISSUE #1. IT IS UNCLEAR WHAT POWERS THE LEGISLATURE HAS TO FURTHER AMEND, REVISE, SUPPLEMENT, OR CODIFY PROVISIONS OF THE INITIATIVE ACT WHICH PROVIDES FOR THE PRACTICE AND LICENSURE OF DOCTORS OF OSTEOPATHY.

BACKGROUND: Unlike other licensing boards reviewed by the Committee, this Board and its licensing act was created by an initiative in 1922. Any changes made to this act have had to be submitted to the voters for approval.

The act currently provides for a Board consisting of five professional (Doctors of Osteopathy) members and two public members. The Governor appoints all members of the Board. The Board is granted exclusive power to issue a license to those who graduate from an osteopathic medical school. It also provides that the Board shall enforce those portions of the Medical Practice Act dealing with the discipline of physicians and surgeons for specified offenses (Article 12, commencing with section 2220 of the Business and Professions Code.)

In 1962, the Legislature was granted authority by initiative to amend or modify the original initiative act of 1922, and to repeal the act and transfer jurisdiction of the Osteopathic Board to the Medical Board, if the number of persons licensed by this act reached 40 or fewer[1]. However, the Legislature still has no authority to place a sunset date on this Board, and may not have the authority to subject it

[1] Part of that initiative called for an end to licensing of D.O.s by a separate board, and would have required D.O.s to seek licensure by the Medical Board. However, out of state D.O.s sued, and the courts voided that part of the initiative. Thus, the intended dwindling away of D.O. licensees has never occurred.

to the jurisdiction of the Department of Consumer Affairs. This Board operates freely without any oversight of a Department or Agency, nor does it have to meet any of the general requirements and provisions established under Division 1 and 1.5 of the Business and Professions Code for all other licensing boards under the Department.

The issue of the Legislature's authority was tested in 1983, when a law was passed which would have added two more public members on the Board. The Board outright refused to recognize the seating of these two new members. It was their opinion that it was "constitutionally empowered" and beyond the jurisdiction of the Legislature and would continue to proceed as a state agency with only osteopaths as Board members. The Center for Public Interest Law (CPIL) sought a writ and litigated the right of the two public members to sit on the Board. The trial court and the Court of Appeal ordered the Board to seat the two members.

Although the court decided in favor of the Legislature on this occasion, it should be made clear that the Legislature and the Department can propose statutory changes that are necessary to improve the overall effectiveness and efficiency of this Board, rather than having to pursue litigation to implement these changes.

It has been recommended by CPIL that this Board, along with the Board of Chiropractors, be treated the same as other licensing boards under the Department, and that its initiative provisions be codified and subject to change or revision by the Legislature without having to seek a vote of the electorate. In 1993, the Legislative Analyst's Office (LAO) recommended that all boards be consolidated under the Department including the Osteopathic Medical Board.

However, it should also be made clear that the Legislature may not repeal the licensing of these two professions. This is because the Osteopathic Act and the Chiropractic Act were adopted by initiative in response to efforts by other sectors of the medical community to prohibit their right to existence altogether. While it seems unlikely in this day and age that anyone would suggest abolishing D.O.s or D.C.s, these groups have some justifiable, history-based concern. Nonetheless, this rationale does not extend to issues about rational government organization, modern public resource management, and reasonable legislative oversight.

STAFF RECOMMENDATION: ***The law should be amended by a vote of the electorate, placed on the ballot by the Legislature, to ensure the existence of the Osteopathic Physicians in California, but in all other respects treat the regulatory program the same as all other health practitioner licensing boards.***

QUESTION #1 FOR THE BOARD: ***Please indicate if the Board has any concerns about amending the initiative act so that it may be treated like other licensing boards under the Department of Consumer Affairs. In addition, please indicate the extent to which some or all of the changes in law necessary to accomplish parity of treatment could be accomplished without a vote of the electorate.***

ISSUE #2. THE BOARD HAS BEEN UNABLE TO ADOPT REGULATIONS ESTABLISHING A SCHEDULE OF "CITE AND FINE" OR DISCIPLINARY VIOLATIONS SIMILAR TO OTHER BOARDS.

BACKGROUND: The Business and Professions Code provides that "any board, bureau, or commission within the department" may adopt by regulation a system whereby a citation could be issued containing an order of abatement or an order to pay an administrative fine. Fines are capped at $2500 per violation, and the statute provides for a hearing procedure in the event the licensee elects to contest the order.

Because the Board is not "within the department" as required by the statute, it has not adopted a regulation as authorized for virtually all other licensing boards. This authority is a valuable tool for regulators because it provides an expedited procedure to enforce the law where the violation(s) may be relatively minor, and the formal due process required for license suspension or revocation would lead to prohibitive costs. It can also be a valuable tool when the violation(s) relate to financial issues and are not direct quality of care violations.

STAFF RECOMMENDATION: ***The statute should be amended to authorize the Board to adopt cite and fine regulations in the same manner and to the same extent as other boards, bureaus or commissions. It appears probable that this type of amendment is accomplishable by legislatively enacted statute.***

QUESTION #2 FOR THE BOARD: ***Please evaluate the extent to which cite and fine and cite and abate authority would be a valuable enforcement tool. Provide your opinion on whether this authority is within the Legislature's power to grant.***

ISSUE #3. THE BOARD MAY NEED AN ADDITIONAL POSITION TO MANAGE AND MONITOR ITS ENFORCEMENT PROGRAM.

BACKGROUND: The Board currently has 4 employees and sought budgetary approval for a fifth. Finance rejected the request. However, the Board currently lacks staff resources to perform a range of functions that could improve its ability to carry out its enforcement program, as well as prepare and analyze data related to its enforcement operations. For example, statistics presented to the JLSRC had to be culled from paper records. The Board does not have staff resources to manage electronic data that would be valuable analytical information.

Presently, the Board has ample fund resources, and fees are relatively low in comparison to what M.D.s pay in licensing fees to the Medical Board of California. The Medical Board, however, is able to carry out a more sophisticated enforcement program; it can track and monitor its cases better; it can manage its expenses better; and it can respond to requests for data better. D.O.s are equivalent practitioners of medicine, and it makes little sense to provide better tools to one regulator of physicians than to the other.

On the other hand, the Board has had fiscal years when its enforcement budget has been close to depleted before the end of the year. Would adding staff resources in some way limit the Board's ability to fully implement its enforcement program through the end of each fiscal year?

STAFF RECOMMENDATION: ***The Board should continue to pursue a request for an additional staff position, so that it can better monitor its enforcement caseload and improve on the tracking of licensees who are within its disciplinary system.***

QUESTION #3 FOR BOARD: ***Please be prepared to explain to the Joint Committee, as well as to the Department of Finance, why the addition of a staff position will enhance your enforcement program.***

ISSUE #4. THE BOARD HAS HAD TO CURTAIL DESIRED ENFORCEMENT ACTIVITY IN THE PAST DUE TO A LACK OF SPENDING AUTHORITY, EVEN THOUGH ITS OVERALL FUND CONDITION WAS STABLE AND IT HAD ADEQUATE RESERVES.

BACKGROUND: One problem characteristic of the licensing bodies that contract for investigative and prosecutorial services is that late in the fiscal year spending authority may have been consumed by individual significant cases, or by a higher than expected volume of cases. As a consequence, enforcement activity falls off late in the year. This problem has plagued the Board numerous times in years past, although the Board asserts that it has not had to curtail enforcement activities recently.

This problem is particularly acute for relatively small boards or programs. When budgeting, governmental agencies need to be able to estimate a predictable level of activity and use cost assumptions based on averages to identify an appropriate level of spending authority. However, complex or unique individual cases or an unusually high volume year can overwhelm even the most carefully calculated "expected" spending estimate. When a program's fund condition is sound, it is contrary to the interests of public protection to limit a regulatory body's enforcement activity simply because more, or more complex, activity occurred than predicted.

Nonetheless, this reality has occurred with regard to the Board – a regulatory agency charged with protecting the public from incompetent physicians. Should there be a more efficient mechanism to allow the Board to access necessary enforcement funds when higher than expected enforcement costs threaten to limit appropriate late-year enforcement activities?

QUESTION #4 FOR BOARD: ***What mechanisms could be adopted by the Board or the Legislature to ensure that unusual or complex cases do not prevent the Board from carrying out enforcement actions that they would otherwise prosecute but for the budgetary shortfall?***

ISSUE #5. THE BOARD HAS A SIGNIFICANT FUND RESERVE OF ALMOST 20 MONTHS OF BUDGETARY EXPENDITURES. IT IS UNKNOWN WHETHER THIS EXCESS RESERVE WILL LAST, AND IF IT SHOULD BE REDUCED TO A MORE APPROPRIATE LEVEL OF THREE TO SIX MONTHS, AS RECOMMENDED BY LEGISLATIVE ANALYST'S OFFICE.

BACKGROUND: In the early 1990s, fiscal crises struck the state and the Legislature had to address budget shortfalls as large as $14 billion. One of the ways that the crisis was handled was to take excess or reserve funds from programs deemed less vital, and transfer those funds to more critical purposes. In certain circumstances, that meant transferring "special fund" monies to General Fund programs. Unfortunately, courts have ruled that special funds cannot be transferred for that purpose. As a consequence, many special funds, including the Osteopathic fund, were repaid a lump sum to make up

for those transfers. Those funds are now available for use to support the Board. In fact, current income is outstripped by current expenditures by a significant amount each year, and is projected to continue. This may be partially due to the fact that license renewal fees fell from $300 per year to $200 per year as a result of the sunset of the statute that provided for the $300 fee.

Nonetheless, as complaints increase and the demand for enforcement resources increase accordingly, the gap between current income and current expenses will continue to exist, if not grow. As a result, the Board needs to carefully evaluate its long-term funding requirements.

If anything, the Board's report to the JLSRC points to a need for additional enforcement resources, not less. Therefore, cutbacks in enforcement do not appear to be justified. Increases in revenue must be evaluated. There are several options. First, the Board could step up its cost recovery program. Second, the Board could increase the fees for applications and examination purposes so that license renewals do not subsidize those functions. Third, license renewal fees could be returned to the $300 level, or some other level over $200 that would provide a long-term stable funding base.

QUESTION #5 FOR BOARD: *Has the Board evaluated how long, especially in light of the rising level of complaints in comparison to the number of licensees, the excess reserve will last? Please be prepared to discuss your fund's long-term adequacy and the various means of generating revenue that would provide a stable and adequate funding base.*

ISSUE #6. IT DOES NOT APPEAR AS THOUGH THE BOARD IS RECEIVING ANY DISCIPLINARY REPORTS FROM HOSPITALS PERTAINING TO D.O.s. ("805 REPORTS").

Business and Professions Code Section 805 provides that a "peer review body" must file with the relevant licensing board an "805 report" whenever specified actions are taken with respect to a licensee. Peer review bodies include hospital chiefs of staff or CEOs, HMO medical directors, and other professional organizations. The actions that trigger the obligation to file 805 reports include denial or revocation of medical staff privileges for a medical disciplinary reason, restrictions that are imposed for over 30 days within any one-year period for a medical disciplinary reason, as well as a resignation or leave of absence after notice is given that there is an investigation based on information indicating medical disciplinary concerns.

There has been a general sense within the medical community that the 805 reporting system is simply being ignored. According to audits by the Medical Board of California, some hospitals have never filed a report, and others have done so only in the most extreme cases. Where a report should be filed but is not, the party responsible for that failure is subject to a civil fine of up to $5000, payable to the Board based on an action filed by the AG. The Medical Board of California has sought and enforced these fines, but nonetheless has publicly maintained that there is broad-based noncompliance with the law.

Data provided by the Board does not break out 805 reports as the source of complaints, but instead describes the type of person making the report. For example, over the past 4 fiscal years, 4 complaints have come from "Insurance Company referrals" and these could be 805 reports, or they could be fraud-related reports. In addition, "D.O. and M.D. referrals" constitute 13 complaints over the past 4 years. Hospital referrals are not specifically broken out. Unfortunately, a large number of the complaints received by the Board (consistently in the range of 1/3 of the total number of complaints) are listed as from "Other" sources.

The premise of 805 reporting is that professional peer review sources can act as the early warning system for potentially problem physicians. In addition, by placing a mandate in the law, there is less possibility that a professional review entity will "sweep it under the rug" when a potentially embarrassing situation arises at a hospital. However, this latter reason tends to cause reticence among those obligated to report, and compliance, at least in the opinion of some knowledgeable observers, has been poor.

QUESTION #6 FOR BOARD: ***Are these peer review bodies complying with the statutorily mandated reporting system (so-called "805 reports") that requires peer review bodies to notify the board of adverse actions taken against physicians?***

ISSUE #7. IT IS UNCLEAR WHY DISCIPLINARY CASES OF THE BOARD ARE BEING REFERRED TO THE ATTORNEY GENERAL'S GENERAL LICENSING UNIT RATHER THAN TO THE "HEALTH QUALITY ENFORCEMENT" (HQE) UNIT. THE HQE UNIT IS USED BY THE MEDICAL BOARD AND HAS ATTORNEYS WHO ARE CONSIDERED SPECIALISTS IN HEALTH CARE ISSUES.

The HQE unit within the AG's office is not separately funded by the Medical Board. While virtually all of its work is dedicated to enforcing the Medical Practices Act against M.D.s with the MBC as its client, those services are billed on a case by case basis to the MBC. Thus, the current financial structure of the HQE would not create subsidies from the MBC to the Board in the event HQE deputies handled Board prosecutions. Instead, as work performed by the HQE for whatever client is performed, it could be billed for that client. If workload increases, staffing could be increased.

The rationale for the HQE is that medical issues are unique, complex, and require specialists to most effectively handle enforcement cases. This is a reasonable approach that has worked well for the MBC. However, there appears to be no reason why disciplinary matters aimed at all physicians should not be handled by these specialists. As far as the public is concerned, there is no difference legally between D.O.s and M.D.s. Each type of licensee can and does provide the full range of physician services to the public and presents the same types of risks to the public when incompetent, unprofessional, grossly negligent, or repeatedly negligent behaviors occur.

QUESTION #7 FOR THE BOARD: ***Please be prepared to discuss whether there is any reason why the Board should not immediately initiate discussions with the Attorney General to commence using the HQE specialists in the prosecution of disciplinary cases initiated on behalf of the Board.***

ISSUE #8. THE CALIFORNIA-SPECIFIC WRITTEN EXAMINATION FOR A D.O. APPLICANT APPEARS UNNECESSARY.

In order for a D.O. applicant to become licensed as a physician in California, he/she must meet certain educational and training requirements, pass a written examination, and pass an oral/practical examination. The written examination requirement can be met in one of two ways: successful passage of the national boards, or successful passage of an examination administered by the OMBC. The OMBC has contracted with the National Board to prepare this California examination (as have a handful of other states.) However, as of November 1, 1999, this service will no longer be available.

In general, licensing examinations must be carefully crafted and validated, so that the test is a fair and reasonable basis to block or allow entry into a profession. That process can be very expensive. This is particularly true if the population of test takers is very small. In the OMBC context, very few applicants take advantage of the examination administered by the OMBC – the vast majority of applicants have taken and passed the comparable examination administered by the National Board of Osteopathic Examiners. From a cost-benefit perspective, it makes little sense to continue to provide a California-administered written examination in light of the substantial up-front costs necessary to develop such an examination.

The existing examination statute reads as a permissive authority. Read in that light, the OMBC could simply cease to exercise that authority. However, counsel for the Board has suggested that the statute could be read to confer on applicants a choice of examination options, and that the Board could be forced to expend substantial resources to generate on its own an examination that would be minimally, if at all, different from the national boards. Counsel has suggested elimination of the offending language.

STAFF RECOMMENDATION: ***Amend Section 2099.5 to delete authority of the Board to use a California-specific written examination.***

QUESTION #8 FOR THE BOARD: ***Should the statute governing initial licensing examinations be amended to delete the provision allowing the Board to provide a California-specific written examination?***

ISSUE #9. THE BOARD HAS INDICATED THAT IT IS UNNECESSARY FOR MEDICAL CORPORATIONS OF PHYSICIANS AND SURGEONS LICENSED BY THE BOARD TO CONTINUE REGISTERING WITH THE BOARD.

BACKGROUND: Pursuant to Section 2454 of the Business and Professions Code, a medical corporation that has physicians and surgeons licensed by the Board must register with the Board and provide specified information. The Board has indicated that it believes this requirement is no longer necessary.

STAFF RECOMMENDATION: ***Eliminate Section 2454 of the Business and Professions Code dealing with registration of medical corporations by the Board.***

QUESTION #9 FOR THE BOARD: ***Please indicate why the requirement to register Medical Corporations is no longer necessary.***

ISSUE #10. THE CONSUMER SATISFACTION SURVEY CONDUCTED BY THE BOARD SHOWS EXCESSIVE CONSUMER DISSATISFACTION WITH THE COMPLAINT PROCESS.

As part of the sunset review process, each board or program is asked to conduct a consumer complaint satisfaction survey. The Board sent out a survey and received only 54 responses. Unfortunately, there was a disproportionate number of dissatisfied complainants. Out of the 54 responses, 40 respondents, or 75%, were dissatisfied with the overall service provided by the Board.

In discussing this issue with Board staff, it was suggested that this result is understandable, because those who complain want action taken. However, many issues that people complain about – ineffective antibiotics, the need to go to another doctor to get a more effective prescription, or even poor doctoring, for example – simply are not actionable. Nonetheless, according to Board staff, these patients who file this type of complaint expect some sort of action. When that does not occur, they are dissatisfied. It was suggested that people who feel strongly are more likely to respond to a questionnaire.

However, Board staff also acknowledged that there may be a gap between the Board's legal authority and the expectations of patients who file complaints. In addition, it was conceded that the Board may not do as well as it would like in communicating with the patients who file complaints.

Clearly, the Board needs to do a better job of responding to the expectations of patients who file complaints. It is unclear, however, what measures need to be taken. The Board has only 4 staff persons, one of whom is a receptionist/phone answerer. With these limited staff resources, it is unrealistic to expect that knowledgeable staff would be on hand at all times for any inquiry. But the survey results clearly show that the public is expecting more than it is receiving – be it better information about what the Board can do; better information about the type of conduct and burden of proof needed to pursue an enforcement action; or merely better communication with people who feel that they are a part of the process.

STAFF RECOMMENDATION: ***The Board should evaluate whether it is failing to address complaints properly, or whether it merely needs to communicate better with complainants. The Board should report to the Joint Committee by March 1, 2000, on ways it plans to improve its relationship with complainants.***

QUESTION #10 FOR THE BOARD: ***Please explain from the Board's perspective why it believes complainants are dissatisfied with the overall service provided by the Board, and what measures should be taken.***

PART 3

Osteopathic Medical Board of California

BOARD'S RESPONSE TO ISSUES AND RECOMMENDATIONS FROM 1999/2000 SUNSET REVIEW

1. Department of Consumer Affairs – Inclusion

The later question regarding the amendment of Initiative Act is a legal question more adequately answered by legal counsel; however, Business and Professions Code Section 3600-3 notes "this act may be further amended or modified by the Legislature." Additionally, there was a period of time in the Department 70's when the board was in the DCA and can again be placed in the DCA as long as the existence and authority of the board is not weakened.

The board's chief concern about being in DCA is potential loss of authority and lack of separation from the Medical Board of California. The profession of osteopathic medicine is a distinct and separate profession within the healing arts and is not to be confused with allopathic profession.

2. Cite and Fine

Cite and Fine could be beneficial for minor violations of the Business and Professions Code that do not involve patient harm or narcotics violations. Section 125.9 currently permits boards under DCA to assess cite and fines. A clause can be added to Section 125.9 (a) after "department" as follows: or the Osteopathic Medical Board. Even if the board was not relocated in DCA, adding the above clause to section 125.9 would then give the Board cite and fine authority, thus enhancing the enforcement program. The board, at their recent meeting, authorized staff to seek legislation to grant this authority to the board.

3. Additional Position

This position was requested in FY 00-01. The additional support position should be at least entry level clerical; this position would be used to maintain an accurate data base for compiling complaint and disciplinary action statistics from receipt to completion including those transferred to DCA , DOI or the DOJ, for the future sunset reviews. This position would keep accurate statistics, track the flow of complaints for letters to consumers, letters to physicians and prepare files for consultants review. The board's fund condition can support this position within each budget year and for at least two years. This position would not take away from the enforcement activity funding, but is needed to maintain accurate and complete statistical records. The additional position will speed up the enforcement process.

4. Budget Shortfall for Enforcement

The board has done all it could do in order to remedy the situation. For several years the board has requested either a BCP or Deficiency for enforcement, and the requests have consistently been reduced by nearly 50% by DOF. Funds were available in the Board Reserve. For several years enforcement had to be curtailed in mid-year for lack of funding. All requests for deficiency and/or BCP's were addressed less than encouraging by DOF; i.e., in FY 92-93 enforcement ceased in March '93; FY 93-94 enforcement ceased in January '94; in FY 94-95 a deficiency was requested, but denied. In FY 95-96 enforcement ceased in January '96. In FY 96-97, a deficiency in the amount of $250,000 was requested, however only $160,000 was authorized. In FY 97-98 a BCP in the amount of $350,000 was requested, however, only $200,000 was approved.

If the legislators and/or DOF can grant our BCP/Deficiency requests, this problem wouldn't exist.

5. Fund Condition

Although the reserve fund currently is mostly made up of the monies repaying the illegal transfer, these funds should be available for use. (approximately $1,000,000 is in the reserve, $600,000 is return from illegal transfer) The current reserve will be depleted in approximately 4 years at the current and proposed spending levels. In approximately two years, after the proposed staffing increase, we will know how much we will have to increase fees to meet expenses. The fund condition will be closely monitored for any unnecessary depletion and if it is necessary, we will seek a fee increase by way of legislation to amend Business and Professions Code Section 2455.

Additionally, the number of licensees continues to grow therefore adding to the revenue. It is difficult to estimate the impact of the additional licenses, but it is significant and worthy of noting. Finally, the cost recovery program is sometimes used in the negotiation of a settlement in a given disciplinary case or at the conclusion of a hearing. The next two years can give us a better understanding on how much can be recovered.

6. 805 Report

805 reports are received from several different hospitals throughout the state. The number of 805 reports was included in the complaint totals. It is not known if all hospitals are reporting, but it appears most are currently reporting in view of penalties for not reporting. For example, the following lists reports received:
96-97 = 1
97-98 = 3
98-99 = 3
99-00 = 4

Additionally we receive 805 reports for incomplete records at hospitals. These are not included in the complaint statistics but are as follows:

96-97 = 7 plus 1 (impaired physician 821 Report)
97-98 = 6
98-99 = 3
99-00 = 2

805 Reports are reviewed in the same manner as all other complaints, i.e, records requested from the hospital, input from physician and review by consultants. They are closed in the same manner, "no merit", "with merit" or forwarded for expert evaluation and then to the AG for formal discipline.

7. Health Quality Enforcement

We cannot fully determine, at this time, if, enforcement cases were to be handled by the HQE unit, it would enhance the Board's program. For example, we do not know what the turn-around time is for cases submitted to the HQE and if they are presently experiencing a backlog. Cases are currently handled by the AG's Licensing Section, and the only real delays seem to have occurred in the past in the Los Angeles Unit.

The Licensing Section has many expert attorneys specializing in healthcare issues and they appear to do the job of enforcing healthcare laws for other healthcare boards. Additionally, the inclusion of our cases in the HQE unit discipline pipeline, would not seem to be effective in as much as our cases would be necessarily assigned a lower priority. Also continuing the Licensing Division will assure the distinctness and separation of the two boards (MBC and OMBC). The Los Angeles unit is now aware of the delay in processing our cases, and we are confident that this problem is now resolved especially in view of our anticipated additional staff position.

8. California Written Examination

Yes, it is necessary to amend B&P Section 2099.5 to delete the reference to the OMBC's written exam. OMBC no longer has the option of purchasing the written exam from the National Board for applicants as they have discontinued preparing the exam. It is felt that if the clause is not removed, an applicant who would only be eligible for licensure by taking the "State Written Exam" could challenge the board as the statute is clear that an exam would be available.

9. Medical Corporation Registration

Medical corporations were originally unique and designed to provide physicians with adequate security for claims against it as well as for tax and benefit purposes. In recent years the requirements for registration has greatly lessened and the consumer/patient can now readily identify who is providing treatment to them. As such, no real public purpose is served by a registration requirement. The board will continue to apply the fictitious name permit requirement as a means of assuring identity of practitioner irrespective of the fact that the provider is an individual or corporation.

It should also be noted that the Medical Board of California has already eliminated their statute requiring physicians to register their corporations.

10. Consumer Satisfaction Survey

When a consumer/patient files a complaint they feel they have been mistreated by the physician and revocation or suspension of the practitioners license is what they want and expect as an outcome of their complaint. Consumer/patients are not attorneys and are not familiar with the burden of proof in administrative cases, nor the standards for disciplinary actions. As such, it is felt we can say very little which would convince them that what the physician did or did not do would not warrant revocation or suspension of license. Nevertheless, the survey has shown communication can be improved. The board will conduct a study of the situation and will report to the legislature.

PART 4

Osteopathic Medical Board of California

FINAL RECOMMENDATIONS OF THE JOINT LEGISLATIVE SUNSET REVIEW COMMITTEE AND THE DEPARTMENT OF CONSUMER AFFAIRS

The Following Recommendations were Adopted by the Joint Legislative Sunset Review Committee on April 11, 2000 by a Vote of 5 to 0:

ISSUE #1. (CONTINUE REGULATION OF THE PROFESSION?) Should the licensing and regulation of Doctors of Osteopathy be continued?

Recommendation #1: ***The Joint Committee and Department recommends continued state regulation of this profession.***

Comments: Like other medical care, osteopathic medicine requires a high level of skill. Licensure ensures that osteopaths have the necessary knowledge, skills, and abilities to provide care without causing harm to their patients. In addition, regulation of the profession creates an enforcement structure so that action can be taken when unsafe, fraudulent, or incompetent activities occur.

ISSUE #2. (CONTINUE WITH THE BOARD?) Should the Board be continued, or its role be limited to an advisory body and the remaining functions be transferred to the Department?

Recommendation #2: ***The Joint Committee and the Department recommends retaining the Board as the agency responsible for regulating the practice of osteopathic care.***

Comments: The board structure has proven effective for the regulation of other health professions. The Department has not been presented with any information suggesting a need to change the current regulatory structure for the osteopathic profession.

ISSUE #3. (PLACE THE BOARD UNDER THE JURISDICTION OF THE DEPARTMENT LIKE OTHER HEALTH PROFESSIONAL LICENSING BOARDS?) Should the Osteopathic Medical Board be placed under the jurisdiction of the Department of Consumer Affairs like all other health-related professional licensing boards?

Recommendation #3: ***Given the proven need for flexibility in modifying licensing laws and the potential benefits to the Board from the Department's expertise, the Department concurs with the recommendation of the Joint Committee that the Legislature take action to place an initiative on the ballot to move the Board into the Department's structure.***

Comments: The Osteopathic Medical Board is unusual among state regulatory entities since it is only one of two professional boards established by a voter-approved initiative, rather than by legislative action. Created in 1922, the Board regulates the practice of osteopathic care and is completely independent of the Department, which distinguishes it from the state's other health professional licensing programs. As a consequence, it is not subject to any oversight or administrative process review within the executive branch, as are other licensing boards under the Department. The current structure also prevents the Board from utilizing the Department's regulatory expertise and the administrative economies of scale available to other Department programs. Also, there is some question as to whether the Legislature and the Administration can amend the governing statutes for the Board without voter approval. Thus, routine regulatory changes such as increasing fees, modifying licensing requirements, and updating the osteopathic scope of practice may require an additional, and unnecessary, approval process. Given the proven need for flexibility in modifying licensing laws and the potential benefits to the Board from the Department's expertise, the Department concurs with the Joint Committee recommendation that the Legislature take action to place an initiative on the ballot to move the Board into the Department structure.

ISSUE #4. (SHOULD ALL GENERAL REQUIREMENTS FOR OTHER HEALTH-RELATED LICENSING BOARDS APPLY TO THIS BOARD?) Should all general provisions (and future provisions) of the Business and Professions Code that apply to all other health-related licensing boards under the Department, apply to this Board?

Recommendation #4: ***The Joint Committee recommends that the Osteopathic Initiative Act should be amended if necessary, or statutory changes made, that will assure this Board will be subject to the same requirements as all other health practitioner licensing boards under the Business and Professions Code. Various statutory sections throughout the Business and Professions Code should also be consolidated into one chapter pertaining to Osteopathic practice as recommended by Legislative Counsel.***

Comments: Unlike the Chiropractic Initiative Act, there is direct authority under Section 3 of the Osteopathic Initiative Act for the Legislature to further amend or modify the act as necessary. This authority was granted to the Legislature in 1962 by voter approval. It does not appear that it would be necessary to place an initiative on the ballot to either move the Board under the jurisdiction of the Department or assure that it meet all the same requirements as all other health-related boards under the Department. However, legislation would still be necessary to assure that this Board was subject to these requirements. This would include cite and fine authority, inspection authority, injunctive relief, board and public member requirements, examination and review requirements, periodic sunset review, and all future requirements or changes made by the Legislature that apply to all health-related boards under the Department.

ISSUE #5. (NEED FOR ADDITIONAL POSITION TO MANAGE AND MONITOR ITS ENFORCEMENT PROGRAM?) The Board appears to have the need for one additional position for its enforcement program to improve the tracking of complaints and assure the efficient disposition of enforcement cases.

Recommendation #5: ***The Joint Committee recommends that the Board should seek appropriate spending authority for an additional staff position to improve the tracking and disposition of enforcement cases. The Board's current fund condition could support this additional position.***

Comments: The Board currently has 4 employees and sought budgetary approval for a fifth. Finance rejected the request. However, the Board currently lacks staff resources to perform a range of functions that could improve its ability to carry out its enforcement program, as well as prepare and analyze data related to its enforcement operations. For example, statistics presented to the Joint Committee had to be culled from paper records. The Board does not have staff resources to manage electronic data that would be valuable analytical information. Presently, the Board has ample fund resources, and fees are relatively low in comparison to what M.D.s pay in licensing fees to the Medical Board of California. The Medical Board, however, is able to carry out a more sophisticated enforcement program; it can track and monitor its cases better; it can manage its expenses better; and it can respond to requests for data better. D.O.s are equivalent practitioners of medicine, and it makes little sense to provide better tools to one regulator of physicians than to the other.

ISSUE #6. (ALLOW BOARD TO ACCESS RESERVE FUNDS OR RECEIVE IMMEDIATE APPROVAL OF BCP/DEFICIENCY REQUEST FOR ENFORCEMENT PURPOSES?) This Board, like others under the Department, has had to curtail desired enforcement activity due to lack of spending authority, even thought its overall fund condition was stable and it had adequate reserves.

Recommendation #6: ***This issue is being addressed as a crosscutting issue. As indicated, there should be a more efficient mechanism to allow boards to access necessary enforcement funds when higher than expected enforcement costs threaten to limit appropriate late-year enforcement activities.***

Comments: One problem characteristic of the licensing bodies that contract for investigative and prosecutorial services, is that late in the fiscal year spending authority may have been consumed by individual significant cases, or by a higher than expected volume of cases. As a consequence, enforcement activity falls off late in the year. This problem has plagued the Board numerous times in years past, although the Board asserts that it has not had to curtail enforcement activities recently.

This problem is particularly acute for relatively small boards or programs. When budgeting, governmental agencies need to be able to estimate a predictable level of activity and use cost assumptions based on averages to identify an appropriate level of spending authority. However, complex or unique individual cases or an unusually high volume year can overwhelm even the most carefully calculated "expected" spending estimate. When a program's fund condition is sound, it is contrary to the interests of public protection to limit a regulatory body's enforcement activity simply because more, or more complex, activity occurred than predicted. Nonetheless, this reality has occurred with regard to this Board – a regulatory agency charged with protecting the public from incompetent physicians.

ISSUE #7. (SHOULD DISCIPLINARY CASES BE REFERRED TO A SPECIALIZED UNIT WITHIN THE ATTORNEY GENERAL'S OFFICE FOR MEDICAL RELATED CASES?) The Board has been referring its cases to the Attorney General's general licensing unit rather than to the Health Quality Enforcement (HQE) unit, which is used by the Medical Board and has investigators and attorneys who are considered specialists in health care issues.

Recommendation #7: ***The Joint Committee recommends that the Board should refer its disciplinary cases to the Attorney General's (AG's) Health Quality Enforcement unit, if agreed to by the AG's office and there is evidence that it would enhance the Board's enforcement program.***

Comments: The Health Quality Enforcement (HQE) unit within the Attorney General's office is not separately funded by the Medical Board of California (MBC). While virtually all of its work is dedicated to enforcing the Medical Practices Act against physicians and surgeons (MD's), with the MBC as its client, those services are billed on a case by case basis to the MBC. Thus, the current financial structure of the HQE would not create subsidies from the MBC to the Board in the event HQE deputies handled Board prosecutions. Instead, as work performed by the HQE for whatever client is performed, it could be billed for that client. If workload increases, staffing could be increased.

The rationale for the HQE is that medical issues are unique, complex, and require specialists to most effectively handle enforcement cases. This is a reasonable approach that has worked well for the MBC. However, there appears to be no reason why disciplinary matters aimed at all physicians should not be handled by these specialists. As far as the public is concerned, there is no difference legally between Doctors of Osteopathy (D.O.) and MD's. Each type of licensee can and does provide the full range of physician services to the public and presents the same types of risks to the public when incompetent, unprofessional, grossly negligent, or repeatedly negligent behaviors occur.

ISSUE #8. (SHOULD THE OPTION FOR THE BOARD TO PROVIDE EITHER A STATE OR NATIONAL EXAMINATION BE ELIMINATED?) The Board provides an option for applicants to pass a state examination or a comparable national examination administered by the National Board of Osteopathic Examiners. Very few applicants take advantage of the state examination, and the contractor who provided this examination has discontinued preparing the exam. If the option were continued, the Board would now be required to develop a new state examination.

Recommendation #8: ***The Joint Committee recommends that the Board should seek legislation to delete the requirement that it provide either a state examination or national examination and instead allow the Board to determine what national examination is appropriate.***

Comments: In order for a D.O. applicant to become licensed as a physician in California, he/she must meet certain educational and training requirements, pass a written examination, and pass an oral/practical examination. The written examination requirement can be met in one of two ways: successful passage of the national boards, or successful passage of an examination administered by the Board. The Board has contracted with the National Board to prepare this California examination (as have a handful of other states.) However, as of November 1, 1999, this service will no longer be available.

In general, licensing examinations must be carefully crafted and validated, so that the test is a fair and reasonable basis to block or allow entry into a profession. That process can be very expensive. This is particularly true if the population of test takers is very small. In the Board context, very few applicants take advantage of the examination administered by the Board – the vast majority of applicants have taken and passed the comparable examination administered by the National Board of Osteopathic Examiners. From a cost-benefit perspective, it makes little sense to continue to provide a California-administered written examination in light of the substantial up-front costs necessary to develop such an examination. The existing examination statute reads as a permissive authority. Read in that light, the Board could simply cease to exercise that authority. However, counsel for the Board has suggested that the statute could be read to confer on applicants a choice of examination options, and that the Board could be forced to expend substantial resources to generate on its own an examination that would be minimally, if at all, different from the national boards. Counsel has suggested elimination of the offending language. [The Board recently introduced legislation to eliminate the requirement for the optional examination.]

ISSUE #9. (CONTINUE TO REQUIRE REGISTRATION OF OSTEOPATHIC MEDICAL CORPORATIONS?) The Board is currently required to register medical corporations that have physicians and surgeons licensed by the Board. The Board has indicated that it believes this requirement is no longer necessary.

Recommendation #9: ***The Joint Committee recommends that the Board should seek legislation to eliminate the requirement to register medical corporations that have physicians and surgeons licensed by the Board.***

Comments: Pursuant to Section 2454 of the Business and Professions Code, a medical corporation that has physicians and surgeons licensed by the Board must register with the Board and provide specified information. The Board has indicated that it believes this requirement is no longer necessary. Medical corporations were originally unique and designed to provide physicians with adequate security for claims against it, as well as for tax and benefit purposes. In recent years the requirements for registration has greatly lessened and the consumer/patient can now readily identify who is providing treatment to them. As such, no real public purpose is served by a registration requirement. The Board will continue to apply the fictitious name permit requirement as a means of assuring identify of practitioner irrespective of the fact that the provider is an individual or corporation. The Medical Board has already eliminated their statute requiring physicians to register their corporations. [The Board recently introduced legislation to eliminate this requirement.]

ISSUE #10. (CHANGE COMPOSITION OF THE BOARD?) The current composition of the Board includes five professional members and only two public members (seven total members). The Governor chooses all members of the Board. Most other health-related consumer boards have a better balance of public members to professional members, and all boards under the Department allow the Senate and Assembly to each choose a member of the board.

Recommendation #10: ***The Joint Committee recommends that, since the licensee population of this Board is rather small, about 2100 active D.O.'s, the size of this Board should not be increased. Instead one of the professional members of the Board should be replaced by a public member, bringing the Board's composition to 4 professional members and 3 public members (seven total members). And, if not in direct conflict with the Initiative Act, one public member should be appointed by the Senate and one public member by the Assembly.***

Comments: The Joint Committee has consistently recommended providing a better balance of public members to professional members for health-related licensing boards. There are currently eight health-related consumer boards that have similar professional majorities, (one additional professional member over that of the public membership). Two health-related boards have a public majority. The only super-professional majority boards (with a 2 to 1 ratio) are the Medical and Dental boards.

Since the licensee population of this Board is rather small, about 2100 active D.O.'s, the size of this Board should not be increased. Instead one of the professional members of the Board should be replaced by a public member, bringing the Board's composition to 4 professional members and 3 public members (seven total members). And, if not in direct conflict with the Initiative Act, the Senate and Assembly should each be able to choose one of the public members, since all other boards under the Department permit the Legislature to appoint two public members.